ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

RECEIVED
OCT 13 2021
BY: JR

# COMPLAINT INVESTIGATION FORM

*If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian*

PLEASE PRINT OR TYPE

**FOR OFFICE USE ONLY**

Date Received: Oct 13, 2021 Case Number: 22-37

**A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:**

Name of Veterinarian/CVT: Dr. Rowena D'Monte & Dr. William J. Langhofer, owner
Premise Name: Scottsdale Veterinary Clinic
Premise Address: 7311 E. Thomas Road
City: Scottsdale State: AZ Zip Code: 85251
Telephone: (480) 945-8484

**B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:**

Na[redacted]
Address[redacted]
C[redacted] State[redacted] Zip Co[redacted]
Home Telephone[redacted] Cell Telephone[redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

**C. PATIENT INFORMATION (1):**

Name: Mia Nichols

Breed/Species: Canine Shih Tzu

Age: 10 months Sex: Female Color: Golden

**PATIENT INFORMATION (2):**

Name: NA

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

**D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

*Please provide the name, address and phone number for each veterinarian.*

Dr. Rowena D'Monte
Scottsdale Veterinary Clinic
7311 E. Thomas Road
Scottsdale, AZ. 85251
480 945-8484

**E. WITNESS INFORMATION:**

*Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.*

Dr. Rowena D'Monte
Veterinary Tech Cassidy (office refused to give last name)
Veterinary Tech Haddesah (office refused to give last name)
Hillary Ponder, CVT Hospital Administrator
7311 E. Thomas Road, Scottsdale, Az. 85251 480-945-8484

James & Patricia Nichols, [redacted]

## Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: James Nichols Patricia L. Nichols

Date: October 9, 2021

**F. ALLEGATIONS and/or CONCERNS:**

*Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.*

SEE ATTACHED STATEMENT

On August 18, 2021 we arrived at The Scottsdale Veterinary Clinic at 7:50 am with our 10 month old puppy Mia to have a baby tooth removed. We waited until approximately 8:30 when the tech took us back. We never saw or spoke with a vet prior to surgery. We explained to the tech that we did not want Mia to be put under general anesthesia due to a problem that occurred with their breathing machine when she was spayed and had an umbilical hernia repaired on April 20, 2021. We discussed an alternative to general anesthesia, using a mask to put her under. We requested that the vet read her file regarding her prior surgery involving the breathing machine. The tech said that she saw that in Mia's file and she understood and would speak to the doctor and let her know. We said "Take good care of our baby girl and don't let anything happen to her." The tech said "Oh we will take good care of her." We left the clinic about 8:45 am

Approximately 12 noon we received a call from the tech and she informed us that the vet said it would be better for Mia to be put under general anesthesia for this procedure. My husband, James took the call and reminded her about our discussion of using a mask instead. The tech was insistent that the doctor wanted to use general anesthesia because "it would be easier on Mia." They went back and forth about this until my husband finally consented, deciding to put his faith in the knowledge and experience of the vet.

Approximately 12:45 pm I, Patricia received a call from Dr. D' Monte. She said Mia was put under general anesthesia at 12:30 and two minutes later she stopped breathing and was in cardiac arrest. They were doing chest compressions as we spoke. I was in such shock and disbelief, I handed the phone to my husband. Since Mia was not responding, she asked permission to stop compressions. In total shock, James said "You killed our dog." She defiantly fired back "I did not kill your dog." James said "Do not stop compressions—we are on our way now."

Approximately 10 minutes later, while we were driving, Dr. D'Monte called and again asked if they could stop compressions and I, Patricia, told her "No, you better have Mia breathing by the time we get there." The only concern the vet seemed to have was to get our permission to stop CPR.

We arrived at the clinic around 1:30. The office manager, Hillary Ponder came in and told us how sorry she was for what happened. She explained that a horrible

mistake had been made. We asked to speak to the vet, but Hillary told us she was in surgery.

Hillary said she would personally be doing an investigation into what occurred. She explained what she knew:

Mia was sedated and at 12:30 anesthesia was started. The vet walked away to get an instrument and left Mia on the table with two surgery techs listening to her heartbeat. Two minutes later Mia stopped breathing and went into cardiac arrest. The vet returned approximately three minutes later with Mia in cardiac arrest and she immediately noticed that the pop-off valve was closed and Mia did not get any oxygen for two to three minutes. Hillary said Mia did not suffer, she was unconscious while she suffocated to death. Hillary admitted a mistake had been made and she said "We will do right by Mia."

Hillary said that after the investigation was completed, it would be sent to their indemnity insurance company which is an outside unbiased insurance company for compensation.

Hillary also asked if she could send Mia to Midwestern University for tissue testing. We said OK but as we were driving home we decided against it and called her back. She said they were already on their way. The next day Hillary called and again asked for permission to have tissue samples taken. This time, we gave our permission and went over all the details of Mia's death with Hillary again. It was the same: no new information—a mistake on their part. She said Dr. D'Monte would be calling us, which she never did. Hillary said Mia would be cremated at Midwestern University, but testing and cremation would take about 3-4 weeks.

We spoke with Hillary one more time before August 30. We wanted some accountability for the gross negligence that happened to our healthy 10 month old puppy. She told us we were just going round and round concerning details of Mia's death. We asked that some disciplinary action be taken with Dr. D'Monte and vet techs Cassidy and Haddesah. Hillary refused to give us their last names. Hillary said the techs were removed from working in surgery and were being given additional training. Dr. D'Monte was still doing surgery.

We picked up Mia's ashes on September 10 and asked Hillary to call us with an update. When we picked up Mia's ashes they even had her birthdate wrong.

Hillary called us on September 13 and was very defensive. We asked if the vet was going to be disciplined for her carelessness with Mia and she said she saw nothing to warrant it. We asked if techs would be disciplined, but they were back in surgery and had been given additional training. At this time no one has been made accountable for the carelessness and gross negligence of our puppy's horrifying death.

A few minutes after the call, we received an email from Hillary that any additional communication would be with Zurich American Insurance Company.

This was not the first time at this facility involving an issue with Mia and a breathing machine. The first time was when Mia was spayed and the vet, Dr. Samantha Gans said there was a problem with the breathing machine. She called to tell us that Mia stopped breathing for a couple seconds but she had her breathing again within a few seconds and Mia was fine but she couldn't pull the second baby tooth, thus, the reason for the second surgery. Dr. Gans told us she didn't think it was a problem with Mia, but a problem with the breathing machine. She told us she had trouble with it the day before and she thought it had been corrected. It makes us wonder if there are running problems with the respiratory machines at this facility. That's why we didn't want Mia to undergo general anesthesia. That's why we asked for Dr. D'Monte to read Mia's file on her previous surgery, but we don't know if she did. Three people trained in veterinary care failed to provide the standard of care Mia needed for this simple and routine procedure. We ask that disciplinary action be taken against these three people for their carelessness, gross negligence and disregard for the safety and life of our Mia. We do not want this to happen to another pet and another family to experience the horrific grief and loss that we are enduring.

We would like to know how three people in a small surgical room with our puppy could display such incompetence in a routine procedure to extract one baby tooth. Were the two surgical techs certified? Was the respiration machine checked before the procedure to make sure it was operating properly—especially to make sure the pop-off valve wasn't tightened? Why did the vet walk away from her patient for so long? Why were there no checks and balances made for the breathing machine? How can a tech listening to the patient's heartbeat not realize the patient isn't breathing? What was the other tech doing while the one

listened to the heartbeat? We want to know if respiration machines at The Scottsdale Veterinary Clinic have a pop-off occlusion valve on very machine and a "reverse" PEEP positive pressure relief valve on every machine. Was a chest tube used on Mia when they realized the pop-off valve was closed?

In regard to the incident with Mia, the following is a quote from the website Veterinary Anesthesia and Analgesia Support:

Avoiding pop-off valve related fatalities

There are two inescapable truths:

1. No substitute for a careful check of the anesthetic machine before use.

2. There is absolutely no substitute for a dedicated anesthetic monitoring individual that remains at the patient's side and who has broad monitoring equipment support.

What are the problems associated with pop-off valve use:

1. Valves left closed after the anesthetic machine was used for mechanical ventilation.

2. Valves left closed by an absent-minded anesthetist after providing short-term manual positive pressure ventilation (PPV).

3. Valves left partially closed to facilitate longer term manual positive pressure ventilation (a reflection of the inconvenience associated with constantly screwing the valve closed then open over and over again).

This is a horrible tragedy that did not have to happen. We put our faith, trust and the safety of Mia in Dr. D'Monte and the surgical techs hands to perform a routine procedure. Dr. D'Monte's insistence to use anesthesia "because it would be easier on Mia" cost Mia her life.

We believe The Scottsdale Veterinary Clinic needs to be investigated for the maintenance and safety measures of their respiration machines, implement the appropriate training for the techs utilizing them and insure the veterinarian follows all standard of care protocols for surgical procedures on any animal.

This should never happen to another beloved puppy.

ATTACHED: Necropsy Report
mia's picture

To whom it may concern at Arizona Veterinary Medical Examining Board,

Regarding Case Number 22-37, "Mia" Nichols

I am the Premise Veterinarian for The Scottsdale Veterinary Clinic. I was informed of an anesthetic-related death for patient Mia Nichols. Along with recommending grief counseling for the staff involved in this incident and the owners of Mia, we conducted a thorough investigation of the event. It was determined that the most likely cause of death was human error on the part of one of our technicians involved in this anesthetic event, for not noticing that the pop-off valve was closed. This situation was obviously devastating to the owners as well to our staff who perform thousands of complicated and difficult anesthetic events every year with a greater than 99% successful recovery rate.

After the investigation, we researched what steps could be taken to prevent this scenario in the future. The technicians involved in the incident were both given written corrective action, and performance reviews. In addition, we repeated anesthetic safety training with all technical staff involved in anesthetic events, throughout the hospital.

We have also invested over $20,000 in replacement popoff valves and atmospheric equalizing systems for the scavenger systems. These valves are not readily available in veterinary medicine and were purchased from a human anesthetic supplier. These valves are designed to release at pressures of 20 PSI, even if the popoff valve was inadvertently left engaged. This should eliminate any future issues with human error and safe guard patients from this type of accident.

My heart goes out to the owners, as any unexpected loss of a family member is incredibly difficult.

Thank you,

Dr. Bill Langhofer

**DOUGLAS A. DUCEY**
- GOVERNOR -

**VICTORIA WHITMORE**
- EXECUTIVE DIRECTOR -

**ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD**
1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1-PET (1738) • FAX (602) 364-1039
VETBOARD.AZ.GOV

# INVESTIGATIVE COMMITTEE REPORT

**TO:** Arizona State Veterinary Medical Examining Board

**FROM:** AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM
Carolyn Ratajack
Jarrod Butler, DVM
Steven Seiler - ***Absent***

**STAFF PRESENT:** Tracy A. Riendeau; CVT - Investigations
Marc Harris, Assistant Attorney General.

**RE:** Case: 22-37
Complainant(s): James and Patricia Nichols
Respondent(s): William Langhofer, DVM (License: 3604)

**SUMMARY:**
Complaint Received at Board Office: 10/13/21
Committee Discussion: 3/1/22
Board IIR: 4/20/22

**APPLICABLE STATUTES AND RULES:**
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On August 18, 2021, "Mia," a 10-month-old female Shih-Tzu was presented to Dr. D'Monte to have a deciduous tooth extracted. The dog was anesthetized and intubated. Within a short amount of time, it was noted the dog arrested. CPR was initiated but the dog could not be revived.

It was noted that the pop-off valve on the anesthetic machine was closed.

Respondent is the responsible veterinarian for the premises.

**Complainants were noticed and appeared.**
**Respondent was noticed and appeared telephonically. Attorney David Stoll appeared.**

**The Committee reviewed medical records, testimony, and other documentation as described below:**

- Complainant(s) narrative: *James and Patricia Nichols*
- Respondent(s) narrative/medical record: *William Langhofer, DVM*
- Witness Statement(s): *The Scottsdale Veterinary Clinic Staff*

**PROPOSED 'FINDINGS of FACT':**

1. In April 2021, the dog was spayed and had one of her baby teeth removed by Dr. D'Monte's associate when her oxygen level was suboptimal, therefore she was recovered. There were concerns with the anesthetic machine and not with the dog's health. The dog was discharged later that day and it was recommended the dog be rescheduled to have the other deciduous tooth extracted – upper left canine.

2. On August 18, 2021, the dog was presented to Dr. D'Monte to have a deciduous tooth extracted. Complainants expressed their concern due to the last visit and possible issues with the anesthesia machine. Additionally, the dog had a previous allergic reaction to the distemper parvo vaccine. Complainants did not want the dog to undergo general anesthesia and had previously discussed alternatives for the tooth extraction. Staff reassured Complainants that the dog would be fine.

3. Later that day, Complainants state they received a call from technical staff stating that Dr. D'Monte felt it would be better for the dog to be put under general anesthesia for the procedure. Complainants reluctantly agreed. Upon exam, the dog had a weight = 10.7 pounds, a temperature = 102.2 degrees, a heart rate = 160bpm, and a respiration rate = 40rpm. All systems were evaluated and the dog was deemed a surgical candidate.

4. An IV catheter was placed and the dog was started on Plasmalyte 110mL/hr. The dog was pre-medicated with atropine, hydromorphone and midazolam IV; induced with propofol IV; and intubated. Vitamin B12 was administered as well.

5. According to Dr. D'Monte, while the dog was being intubated and being placed on her right side to ensure the left deciduous canine could be accessed, staff was applying the monitoring equipment on the dog. Dr. D'Monte was starting to elevate the tooth while staff was ausculting the dog. She needed an elevator that was not on her stand therefore she walked to the next dental table, five feet away. When Dr. D'Monte returned, she noticed the anesthesia circuit was disconnected from the endotracheal tube – she reattached the dog and picked up the elevator. When Dr. D'Monte turned back to the dog, she saw that the reservoir bag was inflated to full and taut. She asked if there was a problem with the machine and removed the reservoir bag from the machine. At the same time, technical staff lost an audible heartbeat, which Dr. D'Monte confirmed and initiated CPR. The pop-off valve was noted to be closed at that time, and staff opened it, using the safety occlusive valve to offer positive pressure ventilation as compressions continued.

6. Dr. D'Monte called Complainants to inform them of what had transpired. Complainants wanted CPR to continue while they made their way to the premises. The dog was administered emergency medications – epinephrine, atropine, naloxone and flumazenil.

7. Upon arrival, Complainants were advised that the dog could not be recovered. Office manager, CVT Ponder, advised Complainants that she would investigate the matter and get back to them. Complainants were advised that the pop-off valve was left closed and the dog

did not receive oxygen for 2 – 3 minutes. CVT Ponder also explained that the dog did not suffer as she was under anesthesia. A necropsy was recommended and approved by Complainants.

8. Complainants had conversations with CVT Ponder regarding the loss of the dog and changes that would occur due to error. Complainants were concerned that Dr. D'Monte did not call them afterwards to address the error that happened during the procedure on their dog.

9. Dr. Langhofer, the responsible veterinarian for the premises, stated that due to this event, technical staff involved were given written corrective action and performance reviews. Additionally, they repeated anesthetic safety training with all technical staff involved in anesthetic events. Dr. Langhofer also replaced pop-off valves and atmospheric equalizing systems for the scavenger systems. The valves area designed to release at the pressures of 20psi, even if the pop-off valve was inadvertently left engaged.

**COMMITTEE DISCUSSION:**

The Committee discussed that it was unfortunate that there were two separate incidences with this dog regarding technical staff not properly using anesthetic machines. There is a common thread with the training and supervision of technical staff.

Respondent has made changes with respect to staff training and anesthetic machine upgrades. In this case, Respondent had no direct knowledge or involvement surrounding the death of the dog.

**COMMITTEE'S PROPOSED CONCLUSIONS of LAW:**

The Committee concluded that no violations of the Veterinary Practice Act occurred.

**COMMITTEE'S RECOMMENDED DISPOSITION:**

**Motion:** It was moved and seconded the Board:

*Dismiss this issue with no violation.*

**Vote:** The motion was approved with a vote of 4 to 0.

*The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.*

TR

Tracy A. Riendeau, CVT
Investigative Division